

## **How do surgeons think they learn about communication? Qualitative study**

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### **ABSTRACT**

**CONTEXT** Communication education has become integral to pre- and post-qualification clinical curricula, but it has not been informed by research into how practitioners think that good communication arises.

**OBJECTIVES** To explore how surgeons conceptualise their communication with patients with breast cancer in order to inform the design and delivery of communication curricula.

**METHODS** We carried out 19 interviews with 8 breast surgeons. Each interview centred on a specific consultation with a different patient. We analysed the transcripts of the surgeons' interviews qualitatively using a constant comparative approach.

**RESULTS** Surgeons all described communication as central to their role. Communication could be learned to some extent, not from formal training, but by selectively incorporating practices they observed in other practitioners and by being mindful in consultations. Surgeons explained that their own values and character shaped how they communicated and what they wanted to achieve, and constrained what could be learned.

**CONCLUSIONS** These surgeons' understanding of communication is consistent with recent suggestions that communication education (i) should place practitioners' goals at the centre and (ii) might be enhanced by approaches that support 'mindful' practice. By contrast, surgeons' understanding diverged markedly from the current emphasis on 'communication skills'. Research that explores practitioners' perspectives could help educators to design communication curricula that engage practitioners by seeking to enhance their own ways of learning about communication.

## INTRODUCTION

Health services in many countries have invested in training cancer clinicians in clinical communication. The predominant approach has been to teach ‘communication skills’<sup>1-3</sup>. This assumes that practitioners need to be taught discrete skills or tasks, such as ‘appropriate eye contact’, ‘setting the agenda’ or ‘checking patient understanding’ which can then be deployed and combined to achieve specific communication functions, such as ‘building the relationship’ or ‘sharing decision-making’<sup>4</sup>. However, there is little evidence that communication skills teaching in oncology has improved clinical outcomes or patients’ experience<sup>5,6</sup>. Moreover, critiques over three decades have challenged the validity of reducing communication to specific skills<sup>7-11</sup> and have warned that learning and performing skills might even be inimical to authentic caring<sup>10,12,13</sup>. Unsurprisingly, therefore, a significant minority of cancer doctors are sceptical of communication teaching in its current form<sup>14,15</sup>. For these reasons, alternative or additional approaches for communication education need to be identified and explored.

Clinical communication in cancer care is not just a technical task, but entails ethical dilemmas because it has multiple, conflicting outcomes. For example, practitioners have to give information while maintaining hope, and they have to develop a clinical relationship with patients while remaining emotionally detached and objective<sup>16</sup>. Kleinman<sup>17</sup> suggested that, where individuals are faced with ethical dilemmas in the course of daily life, experts’ guidance about how they should address these is unlikely to be helpful unless it is based on understanding the solutions that those individuals have themselves found. Therefore, a potential source of ideas about how clinicians might be helped to learn about communication is clinicians themselves, who might be expected to have ‘expert’ observations and insights based on their own experience. Surprisingly, however, there is little evidence of how practitioners conceptualise their own learning of clinical communication. While studying information-giving by breast surgeons, we found that they had much to say about their own understanding of

communication and how they acquired good communication. In line with the ‘progressive focusing’ of qualitative work, whereby the data should help shape research aims<sup>18</sup>, we broadened the focus to include surgeons’ perspectives on these issues. Our objectives in this report are to describe how these surgeons thought about communication and, specifically how they thought that good, or desirable, communication arose. Our ultimate aim is to obtain ideas that can inform communication education for surgeons or other practitioners.

## **METHODS**

This report is based on interviews with breast surgeons, gathered during a larger study in which we observed consultations between the surgeons and a sample of their patients and then interviewed both surgeons and patients about these consultations. This design, in which interviews are focused on specific consultations, reduces the tendency for interviews with practitioners to elicit justifications for, rather than explanations of, behaviour<sup>19</sup>.

### **Sampling and participants**

After ethical approval (07/H1005/66), all nine surgeons treating patients for breast cancer at a specialist unit serving a socioeconomically diverse urban population were asked to take part after receiving written study information. All agreed and provided written consent. All had some formal training in communication, varying from undergraduate modules to specialist post-qualification communication skills training for cancer clinicians. For each surgeon, we audio-recorded consultations with patients who had recently undergone surgical removal of a breast tumour (not reported here). In these consultations, surgeons reported on histological analysis of the tumour and discussed treatment plans. Consultations were sampled purposively to include patients with the range of ages, prognoses and socioeconomic backgrounds seen at the unit. Patients provided written consent. After each patient’s consultation the researcher (a

female medical undergraduate intercalating a research degree) separately interviewed the patient (not reported here) and the surgeon. Before each interview she reviewed the relevant consultation recording to inform interview questions (see below), Data collection stopped after we had recruited 20 patients, when new data did not change our primary analysis of information needs and provision. By this point, we had recorded 19 interviews with eight surgeons (one surgeon was too busy to be interviewed about one patient, and the ninth surgeon did not see a study patient).

## **Interviews**

Interviews were semi-structured by an interview guide, which evolved as the analysis proceeded. Surgeons were prompted to describe what they had sought to accomplish in the index consultation, and what they thought they had accomplished. Initially, interviews focused particularly on information-giving. However, from the start, surgeons linked their accounts of information-giving to attitudes to communication in general. Therefore we elaborated our interview guide to include surgeons' attitudes to communication and their thinking on the origin of good communication, and to elicit how they judged their own communication. Using the transcript of the relevant consultation, the researcher linked her enquiries to specific instances of communication. Interviews were conversational, using open questions, prompts, clarification and reflection to facilitate surgeons' talk, with closed questions as necessary to probe specific topics. Mean (and range) duration of interviews was 24.8 minutes(6.1-61.6). Interviews were digitally audio-recorded, transcribed and anonymized.

## **Data analysis**

We initially analysed the consultation and interview data together, as reported previously<sup>20</sup>. For this report, we analyzed the surgeon interviews alone. We followed a constant comparative approach, drawing from a grounded theory framework<sup>18</sup>. That

is, we: read, re-read and discussed the transcripts sequentially, comparing each to our understanding of the previous transcripts from that surgeon or other surgeons; inductively and iteratively developed and refined broad analytic categories to distinguish recurrent features of surgeons' talk that were relevant to the research objectives; tested, refined and elaborated these categories through theoretical sampling from the available data to ensure categories that were coherent and discrete. Procedures alone are, however, insufficient to ensure quality of qualitative research<sup>21,22</sup>. Therefore, quality of analysis was enhanced by continually testing alternative formulations<sup>23,24</sup>, reviewing it constantly according to its catalytic validity (potential utility for practice and research<sup>25</sup>), and by respondent validation whereby we discussed the emerging analysis in later interviews and presented the final analysis to the participating surgeons collectively. Whereas analysis was shaped by commonalities across the data we also attended to heterogeneity and divergence, consistent with use of 'deviant' data in qualitative research<sup>26</sup>. NM led analysis, discussing it frequently and in detail with PS and BY, who also read all transcripts.

We present data from surgeon interviews to illustrate categories of the final analysis. For extended quotations, we indicate the surgeon number. Ellipses signify omitted speech. Square brackets mark explanatory text.

## **RESULTS**

### **Sample characteristics**

Of the eight surgeons who provided data, four were consultants (two female, two male); two were 'staff grade' (both female), i.e. taking consultant-level responsibility; two were in specialist training (one male, one female).

### **Communication was central to being a surgeon**

Surgeons all talked freely about communication as a central and challenging component of professional competence, as the findings below indicate. They all described having goals or aims that directed how and what they communicated and that often evolved during consultations. For example, *“I always walk in with an aim...Sometimes it changes, a bit like with this lady and...then I do...sort of move it on...so I will change it then”*(S7).

### **Communication can be learned**

All but one surgeon talked of communication as learnable to some extent. None, however, referred to learning ‘skills’, in the sense of communication elements such as ‘setting the agenda’ or ‘appropriate eye contact’ predefined as skills by other experts. Neither did they describe learning to follow expert provided protocols for specific situations such as ‘breaking bad news’. Instead, they selected what to learn according to what it achieved; and they learned by emulating other practitioners and by being mindful of their own communication.

### **Learning by observing experienced practitioners**

Surgeons described observing other experienced practitioners and selecting aspects of communication that they wanted to “*emulate*”. As one explained, *“I haven’t been taught any way to do it. It’s watching other people. I’ve adapted it from watching other people...I’ve taken some big things on board from seeing other people”*(S8). Some described appraising and learning from peers: *“There’s some people who I think are terrible at giving information. I’ve learnt, I’ve been working with someone in the last year who is very clear...and I’ve realised I’m trying to move over to that way”*(S8). One described learning from a breast nurse: *“I pretend I’m [breast care nurse] and do it [her] way”*(S4). Others learned from senior colleagues while training: *“the junior doctors have to follow [i.e. accompany] the senior doctors for at least a few clinics and so they can adapt their best method from watching different doctors*

*and they can always adapt their own style. It's not 'there is a fixed set way'”(S5). In general, surgeons described learning discrete strategies in this way rather than more general approaches. For example: “I have seen a lot of consultants do that [greeting]. And they make out ‘Oh hello how are you [emphasised]?’...I can see that they don’t recognise the patient but they’re letting the patient think that they’re remembering them individually”(S4). Similarly, another surgeon recounted how “writing them [results and treatment implications] down as clear steps is something I’ve picked up from another senior consultant”( S8). Seeing other practitioners communicate also “gives you extra confidence as well. So you can compare your performance with other consultants or senior people, junior people and you can judge and you can improve”(S3).*

Conversely, consultants described observing and giving feedback to junior colleagues to help them learn, both at the level of general advice such as “Use humour where that’s appropriate. Don’t be afraid of silence. Don’t be afraid of emotion if people are crying or upset”(S1) and more specifically to attend to the words they used:

*“Words like ‘unfortunately’ and ‘I’m very sorry’ are not good words to be associated with cancer. And a lot of people who don’t have English as their first language will use those words and you have to pull them up...I’ve been surprised with registrars who I thought were very good communicators and then you go in and suddenly you realise that actually there’s some poor bits about their communication(S7).*

Where surgeons recalled communication skills teaching, they criticised its ‘artificial’ nature, for example “The woman who’s acting [simulated patient] a bit false and I wasn’t that convinced that she was reacting particularly like a patient”(S2). It felt unrealistic by comparison with what surgeons could learn from colleagues:

*“In the [communication skills] course they will tell you ‘you should see their eyes, encourage the patient’...But you won’t implement it as such. But when you see a surgeon [observe colleague’s practice]...some people use words*



*which are not so good but others...those words subconsciously go into your mind. So when you go next time you try to emulate the good words and the way they communicate... And the courses, they can give you an outline but watching other people do it and taking you through a bit more like taking your hand and showing you round.”(S3).*

Surgeons rejected specific strategies that they associated with communication skills teaching. For example, *“I don’t as a rule ask my patients to repeat what I have said because it doesn’t sound nice”(S2).* Another complained about

*“this whole concept that you have to be ‘What do you think about this? What do you think about that?’ Actually I think you have to do that with some patients...but I don’t think you need to do it every other word...We’ve had some registrars coming in saying ‘Oh you’ve got a cancer, what do you think?’ and they’re [patients] like ‘Well I’ve never even thought about it, you know, actually what I want you to do is tell me what you’re gonna do with it’”(S7).*

Similarly, S4 described finding her own way to communicate, *“whatever they say in the communication skills”*. She had, however, registered for an advanced communication skills course from which she hoped to learn specifically about managing conflict:

*“It teaches you negotiation skills in difficult situations... Not necessarily about breaking bad news because we’re giving that regularly, but for confrontation situations with patients...For instance like [patient] when she found the information difficult to accept and the situation where her husband was pushing against her having reconstruction”(S4).*

### **Learning by being mindful**

Communication was *“something that you have to consciously be aware of”(S9)*. This included being mindful of the patient’s manner and responses; for example *“How much she wants to know, how much she speaks...That gives me an idea, whether she*

*is smiling...whether they are talkative or not talkative...then you can adjust your conversation around that”(S4). Many surgeons described learning from patients in this way: “I’ve learned that the patient’s not taking in a very large amount of what I say...that I am only one giver of information, that although I think I’m saying all the right things to the patient they’re only listening out for certain words”(S8).*

Surgeons also attended to, and reflected on, their own behaviour. One explicitly referred to being “*self-judging, concerned that I might not be quite right*”(S7). Others questioned aspects of their communication with one or more patients: “*I didn’t feel 100% satisfied, you know, I’ve only felt 80% satisfied...because I didn’t specify that it was a ductal cancer and she actually asked that question, so that must have been something that was playing on her mind*”(S4). S3 was dissatisfied with his explanation of results: “*I was unprepared...I was struggling to say ‘You’ve got a tumour you know’*”(S3). Not all dilemmas felt soluble. S8 described difficulty with the usual sequence of consultation in which examination was followed by discussion of results: “*When I’m examining the wound bit I almost don’t want to meet their eyes, you know, because I know they want me to tell them good or bad, and they may stop listening then. But I can’t see a way to improve that*”(S8).

When consultations went smoothly “*you don’t worry...only if you’ve got a hiccup then you think ‘What did I say? Why did things go wrong?’*”(S4). When ‘bad news’ was to be given, the way that surgeons communicated was less “*automatic*”, more “*thought through...before you speak...so you kind of feel the process*”(S4).

### **Communication expresses the surgeon’s character**

All surgeons emphasised the overriding importance of their individual character in shaping both their communication aims and methods: aims expressed their values; and each surgeon had to find what ‘worked’ for him or her.

In describing their aims, most surgeons described their communication as portraying themselves “*fundamentally*” and “*personally*” or expressing “*who I am*”(S6,S7) or the “*way I am*”(S1,S8). In describing their communication with patients they often referred to their own character, for example that they were “*personally...straight*”(S6), “*a friendly guy*”(S2) or “*informal*”(S4,S8). They linked how they communicated to their “*philosophy driven beliefs*”(S1), for example explaining that “*fundamentally I’m a believer in truth and telling the truth and I, I guess that would influence me in why I don’t overdo the positive*”(S1). Moreover, they wanted patients to recognise these qualities. For instance, S3 explicitly recounted that: “*I want the patient to consider me as somebody who is a friendly person, who is here to help me and who I can speak to*” and described talking informally to patients so that “*she can judge me, you know... ‘I am caring how you are’*”. Surgeons described seeking “*rapport*” or “*connection*” with patients; therefore, their own personal interest in patients underpinned the relationship: “*If you like [emphasized] people, if you’re interested in people’s personalities and interested in whether you can make a diagnosis of the disease or help them go along their way...then I think that’s a very positive thing to do and I get a lot out of that*”(S7).

In describing their communication styles, surgeons therefore emphasised that their personalities shaped communication and constrained what could be changed. That is, they could “*refine*” and “*polish*” communication but “*you can’t change fundamentally who you are*”(S8). Therefore practitioners would inevitably differ in their ability: “*Some people have...a natural tendency...and some people have to develop it...You can make an improvement, even though you may never be as good as somebody who’s very empathic*”(S1). S3 explained that “*most of the time what I do is mine. And I took a few things from other people but most of the things are my personal routine. That is what comes out in the consultation*”(S3).

Several surgeons talked of the importance of their learned behaviour feeling natural. S3 explained that initially “*I was maybe a bit more thinking about some of the things I*

*should follow. And then once you do a few more things then it comes...like driving the car, you know, you are doing all these things and then the consultation goes fine and you feel comfortable then".* Similarly, S4 expected that it would take time for her communication to feel natural: *"At the moment I think I'm only probably 40% self, 60% acting because I'm still learning how to communicate. And I'd anticipate that will change and I'd feel more natural the more practice I get. And it is improving with time".*

## **DISCUSSION**

Surgeons talked in detail about their approach to the challenges of clinical communication, describing communication as central to their professional role. They judged their communication according to the extent to which it felt natural and consistent with their goals for the patient and their own values and character. They emphasised modes of learning that involved watching other practitioners and shaping and moulding their own practice by constant reflection on it and on how it affected patients.

While surgeons valued communication and thought it could be learned in part, their accounts of learning diverged markedly from the language of 'communication skills' teaching. They did not describe communication being built up from discrete elements, and they did not talk of acquiring discrete 'skills', in the sense of behavioural elements predefined by others. Neither did they refer to externally provided protocols, such as around breaking bad news. Indeed, the surgeons generally thought that what they learnt from formal training was artificial. Instead, they primarily described communication holistically, referring to their personal aims and style.

Surgeons provided cogent accounts of two processes whereby they did learn to communicate. First, they learned by emulating colleagues; this was not unconscious 'modeling', or socialisation into senior practitioners' practices; rather they consciously

appraised and selectively and deliberately incorporated aspects of the practice of experienced colleagues – including nurses' – in ways that helped them achieve their own communication goals. Surgeons' emphasis on their own individuality helps to explain their attitude to learning from others. That is, because they wanted to communicate their individual values and character, they selected what to learn. What they learned from other practitioners was therefore 'tips' that they could deploy when they wished, rather than general rules. Their sense of authenticity arose from feeling in control of what they learned. Our findings help to understand the paradox that surgeons across specialties rate themselves competent at communication, while also wanting training<sup>27</sup>; for surgeons in the present study, learning communication was not a task that could be completed when a prescribed level was reached. Rather, it was a way of 'being in relation' to patients that was central to their practice and ongoing development<sup>28</sup>.

The second process of learning that the surgeons described was being attentive to patients and curious about them, and aware of their own behaviour and feelings. Surgeons' accounts evoke Epstein's advocacy of mindfulness as a way for practitioners to improve their communication<sup>29-31</sup>. Formal mindfulness practice usually centres on meditation<sup>28</sup>, but it seems that these surgeons acquired some of the characteristics of mindful practitioners without this. Contrary to suggestions that being exposed to patients' distress is inevitably burdensome and therefore practitioners are motivated to deny this distress to protect themselves<sup>2,32-35</sup>, Epstein suggested that mindful practice attunes practitioners to patients' emotional distress without exposing them to being emotionally burdened<sup>36,37</sup>. Surgeons in the present study talked freely of patients' distress and emotional needs, without any evidence of feeling burdened or overwhelmed by it. We have no information on how they acquired this attitude, and future research with surgeons at different levels of seniority could explore its origin.

The study has limitations. Our interviews focused on communicating information, rather than communication more generally. However, information-giving is one of main communication challenges for cancer clinicians<sup>38</sup>. Moreover, the surgeons talked widely about communication, not confining themselves to information-giving, and we prompted them about their attitudes to communication in general. We had only 19 interviews, with eight surgeons in a single unit. However, by grounding interviews in accounts of specific patients we were able to avoid the generalised normative accounts that can arise from interviews with practitioners. Although these surgeons were consistent in their accounts of the main influences on their communication, it is possible that surgeons in other units would give different accounts, pointing to different implications for teaching communication. However, as a qualitative study, our aim is not to generalise our findings, but to provide transferable insights that could inform future work.

Our surgeons' accounts suggest directions for both education and pedagogical research. For education, our findings converge with two approaches that stand apart from the current emphasis on 'communication skills'. First, practitioners' aims or goals, rather than skills, might be the starting point for education, because goals determine the communication behaviours, or skills, that clinicians use or want to learn<sup>39</sup>. Although there are interesting pointers to this approach in primary care,<sup>40</sup> Epstein and Street observed that the cancer communication literature still has a continuing emphasis on skills, or behaviours, rather than outcomes<sup>41</sup>. Secondly, it may be possible for training to support or enhance practitioners' 'mindfulness' in their practice on the grounds that this is more likely than skill training to produce attentive, curious and reflective practitioners<sup>37</sup>. For researchers, the lesson of our findings is that it is very important to illuminate how practitioners conceptualise their communication because they may do so in ways that can inform pedagogical development.

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